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No. 03-69

IN THE

Supreme Court of the United States

VYTRA HEALTHCARE AND BRENT SPEARS, M.D.,

Petitioners,

v.

BONNIE CICIO,

Respondent.

On Petition for a Writ of Certiorari
to the United States Court of
Appeals for the Second Circuit

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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ARGUMENT

POINT I

THIS COURT HAS ESTABLISHED A NEW ERISA JURISPRUDENCE

In *Pegram v. Herdrich*, 530 U.S. 211 (2000), this Court established a new ERISA jurisprudence while considering whether HMOs and capitated medical groups were fiduciaries under ERISA. In the case, this Court identified the three types of decisions made within the health care context: "pure eligibility," where a decision pertains solely to ascertaining whether a condition is covered pursuant to the policy, "pure treatment," where a physician engages in medical conduct, including diagnosis and treatment of a patient, and "mixed eligibility and treatment" decisions. These latter determinations are medical decisions made within the context of pre-authorization and have been defined by this Court in *Pegram* as including

> physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities . . . ; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition. *Id.* at 230.

In *Pegram* this Court ruled that HMOs were not considered to be fiduciaries and stated that claims implicating mixed eligibility and treatment decisions were not those made by a fiduciary, were preempted by ERISA, and allegations of negligence related to these determinations should be pursued under state medical malpractice law. However, although *Pegram* was a case pertaining to an alleged breach of

fiduciary duty involving a capitated medical group, this Court apparently has subsequently indicated that the new jurisprudence applies to all mixed eligibility and treatment decision-making regardless of the form of the entity making that determination. In *U.S. Healthcare Systems Systems of Pennsylvania, Inc., v. Pennsylvania Hospital Insurance Co., 530 U.S. 1241 (2000)*, this Court granted certiorari in the case of *Pappas v. Asbel,* 724 A.2d 889 (1998) *("Pappas I")*, where the Pennsylvania Supreme Court determined that an HMO's delay in providing authorization for a patient to receive emergency neurological treatment resulting in the patient's quadriplegia was negligent. This Court vacated the judgment of the Court and remanded the case to that court for "further consideration in light of *Pegram v. Herdrich.*" *U.S. Healthcare Systems* at 889.

It can only be assumed that this Court intended for the Pennsylvania Supreme Court to consider *Pappas I* in light of the new "mixed eligibility and treatment decision" language in *Pegram* since there was no issue of fiduciary duty in *Pappas I.* It seems logical to conclude that instead of limiting the scope of *Pegram* by refusing to review the case, this Court expanded the parameters of *Pegram* with its vacatur and instructions for review in *U.S. Healthcare Systems*, thereby fashioning a jurisprudence that applied to all types of managed care entities making the determinations this Court identified as "mixed eligibility and treatment."

POINT II

THERE IS NO CONFUSION WHETHER ERISA PREEMPTS MIXED ELIGIBILITY AND TREATMENT DECISIONS

The thrust of the petitioners' argument is that there has been confusion in the courts regarding whether, after *Pegram*, ERISA preempts state law claims involving medically based eligibility determinations. Despite the petitioners' contentions, courts have not only not been confused but have, almost uniformly, accepted both this Court's jurisprudence espoused in *Pegram v. Herdrich* and the unarticulated principle from *U.S. Healthcare Systems* that the tripartite jurisprudence applies to HMOs and managed care entities regardless of their structure.

A. Courts Have Correctly Applied *Pegram*.

Courts which have considered cases where *Pegram* might apply have, with one exception, correctly applied this Court's jurisprudence. Although the petitioners would like this Court to believe otherwise, all the cases they mention, with this exception, have approvingly cited *Pegram* and have correctly decided claims intersecting with the jurisprudence.

1. Courts Have Consistently Correctly Applied *Pegram* To Claims Related To Utilization Review And Mixed Eligibility And Treatment Decisions.

Claims related to utilization review and the applicability of *Pegram* have been addressed by various courts. There is uniformity among the courts that *Pegram* now defines a new category which applies to claims alleging wrongful denials of physician recommended treatment. And all the courts, with one exception, have drawn the correct conclusions from the acceptance of *Pegram* and applied this case both in the

contexts of U.S.C. § 1132(a)(1)(B), (ERISA § 502(a)(1)(B)) and U.S.C. § 1144 (ERISA § 514)).

The Second Circuit, in the case at bar, applied this Court's new tripartite jurisprudence and identified that the HMO and its medical director were making mixed eligibility and treatment decisions when they made two medical decisions related to the requested treatment for the decedent's multiple myeloma: the first identified the treatment as experimental, while in the second, the company substituted its medical judgment for that of Mr. Cicio's doctor, recommending that Mr. Cicio only receive a single stem cell transplant. In reversing in part, the Court ruled that mixed eligibility and treatment decision making does not lead to either complete preemption pursuant to ERISA § 502(a) or § 514.

In *Land v. CIGNA Healthcare of Florida*, 2003 U.S. App. LEXIS 15080 (11th Cir. July 30, 2003), the Eleventh Circuit Court of Appeals ruled consistent with Pegram and approvingly cited the Second Circuit Court of Appeals' decision in *Cicio*. In *Land*, the plaintiff had developed an infection in his hand which his physicians determined required in-hospital treatment. The CIGNA approval nurse, upon review of the admission, determined that the infection was not sufficiently severe to warrant hospitalization and decided that the intravenous antibiotic treatment should be provided on an out-patient basis. By the following week the plaintiff's condition had worsened considerably and ultimately resulted in amputation of his finger.

The plaintiff filed suit in state court alleging that the defendant was negligent in the care and treatment of his infection. The defendant removed the case to federal district court where it was dismissed because the court considered the claims completely preempted by ERISA. The plaintiff appealed and the Eleventh Circuit Court of Appeals reversed, utilizing this Court's jurisprudence in *Pegram*. The Circuit

Court determined that the nurse "'made a patient-specific prescription of appropriate treatment by denying one treatment and authorizing another.' *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003)." *Land* at 15.

The Court, citing this Court's ruling in *Pegram*, determined that the plaintiff's claims were about mixed eligibility and treatment decisions and were therefore not preempted by ERISA § 502(a), thus failing to provide the federal court with jurisdiction.

> Having determined that Land's malpractice claims were not based upon a pure eligibility decision, but rather upon a mixed decision of eligibility and treatment, we must consider whether mixed decision claims are claims "to recover benefits" under section 502(a)(1)(B) and therefore completely preempted. Once again, we find the reasoning of Pegram persuasive. In reaching its conclusion that an HMO does not act as a fiduciary when it makes a mixed eligibility and treatment decision, the Court reiterated its prior holding "that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." Id. at 237. The Court therefore expressed strong doubt that Congress intended to federalize and preempt state law malpractice claims by converting them to fiduciary claims under section 502(a)(2) or to "apply[] an ERISA standard of reasonable medical skill." n4 Id. at 236. In our view, it makes little sense to believe that Congress did not intend to federalize malpractice claims under section 502(a)(2), but intended to do so under section 502(a)(1)(B). *Land* at 16-17.

In *Isaac v. Seabury & Smith* et al., 2002 U.S. Dist. LEXIS 12413 (S.D. Ind. July 5, 2002), the Indianapolis District Court also found that, consistent with the reasoning in *Pegram*, claims that related to mixed eligibility and treatment decisions were not preempted by ERISA and provided the court with no jurisdiction pursuant to ERISA § 502(a). In Isaac, the decedent, who participated in a fee-for-service health plan, contracted leukemia for which her oncologist requested a bone marrow transplant from an appropriate donor. Although the initial request was denied because the company stated it was not a covered expense under the plan, on appeal approval was given; tragically, the patient died before any transplant could occur.

The decedent's representative filed suit in Indiana state court and the defendants removed the case to the Southern District of Indiana, Indianapolis Division, arguing that all the claims should be completely preempted by ERISA and dismissed. The court analyzed the claim based on the tripartite distinction utilized in *Pegram* and ruled that it was a "mixed eligibility and treatment decision" not preempted by ERISA § 502(a).

The court also identified that the new jurisprudence applied to all such mixed eligibility and treatment decisions, regardless of the form of the decision-maker:

> In view of the Court's outline, we think it evident that the decisions at issue in this case come under the heading of mixed decisions of eligibility and treatment. Pursuant to determinations made by physicians -- "a board certified oncologist" in the first instance, and Dr. Sheila Donnelly in the second -- Seabury & Smith made two decisions: one denied Ms. Ambrugey coverage because the

> requested transplant procedure was not "medically necessary"; the second countermanded the first -- in effect, finding it to be within the bounds of "medical necessity" -- and gave "conditional approval" for the operation. Both decisions manifestly involved a question of coverage/eligibility – whether the costs of the bone marrow transplant operation would be covered or (essentially the same thing) whether Ms. Ambrugey was eligible for a transplant -- and a treatment decision – whether a transplant was medically necessary. *Id.* at 18.

The court also stated that:

> We see no clear distinction between a "quasi-medical/administrative decision" and a "mixed decision of eligibility and treatment." *Id.* at 25-26.

The two state courts that have considered ERISA § 514 preemption in relation to claims of wrongful denials of care in the utilization review process both found hat ERISA § 514 did not provide a defense to the claims. ....In *Pappas v. Asbel,* 564 Pa. 407 (2001) *cert. denied sub nom U. S. Healthcare Sys. Of Pa. Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002) ("*Pappas II*"), the Pennsylvania Supreme Court affirmed its prior decision of negligence by the HMO in the pre-certification process, and, in so doing, utilized this Court's tripartite structure. The court first noted that it was irrelevant who was making mixed eligibility and treatment decisions:

> The HMO in *Pegram* was owned by its physicians. U.S. Healthcare contracts with independent physicians to provide services. Pegram's result was based on the nature of the HMO's decision, not on the structure of the HMO making it. *Pegram*, 530 U.S. at 229, 120 S. Ct. at

2155. Further, **the Supreme Court's holding was all-inclusive as to HMOs. Id. Thus, the difference in organization between the HMO in Pegram and U.S. Healthcare is not relevant to this analysis.** [Emphasis added] *Id.* at 1094.

Furthermore, the court stated that:

While Travelers and Pegram deal with different aspects of ERISA, for our present purposes, they share common ground. Travelers instructs that ERISA does not preempt state law that regulates the provision of adequate medical treatment. Pegram instructs that an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach. **Thus, if Haverford's third party claim against U.S. Healthcare arose out of a mixed decision, it is, according to Pegram, subject to state medical malpractice law, which is what Haverford asserted. Moreover, under Travelers, it is not preempted by ERISA.** [Emphasis added] *Id.* at 1095.

In affirming its decision, the court ruled that the defendant had made mixed eligibility and treatment decisions which were not preempted by ERISA:.

In our view, the undisputed facts in this case, and the inferences drawn from them, establish the sort of mixed eligibility and treatment decision that Pegram discussed. Dr. Leibowitz, U.S. Healthcare's physician, reviewed Pappas' case, and rejected another medical doctor's opinion based on his clinical judgment that Pappas needed to be referred to Jefferson for

> treatment of a medical emergency. Instead of referring Pappas to Jefferson, a non-HMO hospital, as Dr. Dickter recommended, Dr. Leibowitz referred Pappas to one of three other facilities for medical care. He did not, in the Supreme Court's words, only make a "simple yes or no" decision as to whether Pappas' condition was covered; it clearly was. Rather, Dr Leibowitz also determined where and, under the circumstances, when Pappas' epidural abscess would be treated. **His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as Pegram teaches, through state medical malpractice law. This law as Travelers teaches, is not preempted by ERISA.** [Emphases added] *Id.* at 1096.

And in *Eid v. Duke*, 816 A.2d 844 (Md. 2003), the plaintiff alleged that the benefits administrator of a disability plan had notified him that he had to return to work and this caused him to be injured. However, the administrator had made no medical determination and the Maryland Court of Appeals ruled that the claim was preempted by ERISA. The Court, in approvingly citing *Pegram,* noted that "the issue of preemption is inextricably bound up with the availability of a traditional medical malpractice claim under state law." *Id.* at 852. This is, indeed, correct, since the viability of the defense of ERISA § 514 is clearly fact-dependent and related to medical decision-making.

2. The Cases The Petitioners Cite Correctly Utilized Pegram And Ruled Consistent With This Court's Jurisprudence.

The petitioners, in arguing that there is confusion among the courts, actually present cases which have correctly adopted the reasoning in *Pegram* and have ruled accordingly. In *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 366 (3d Cir. 2001), the Third Circuit considered the case of whether the failure to provide approval for out-of-network care was negligent resulting in harm to the patient. In making its determination that the consideration of in- versus out-of-network providers was a purely administrative function and not preempted by ERISA, the Court referenced *Pegram* approvingly:

> The recent Supreme Court decision in *Pegram v. Herdrich,* 530 U.S. 211, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000), suggests preferable terminology. Although that case concerned fiduciary acts under ERISA and not preemption, the distinction made there between "eligibility decisions," which "turn on the plan's coverage of a particular condition or medical procedure for its treatment," and "treatment decisions," which are choices in "diagnosing and treating a patent's [sic] condition," 120 S. Ct. at 2154, is equally applicable for complete preemption analysis. Regardless of the language used, the ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of the medical treatment performed, which may be the subject of a state action. *Id.* at 273.

Furthermore, the Court stated that:

> In the case before us, as we note above, Pryzbowski's claims against U.S. Healthcare are limited to its delay in approving benefits, conduct falling squarely within administrative function. A holding that Pryzbowski's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists), which the Supreme Court eschewed in *Pegram*. Cf. 120 S. Ct. at 2156-57 (rejecting claims attacking financial incentives behind HMO structure, in light of congressional policy of promoting HMOs). *Id.* at 275.

Likewise, in *Marks v. Watters,* 322 F.3d 316 (4th Cir. 2003), the Fourth Circuit Court of Appeals correctly applied the principles of *Pegram* and found the claims preempted. In Marks, the representative of the decedent sought damages alleging that the decedent, who had committed suicide, had not been properly treated. In addition to suing, among others, the physicians and the hospital, the plaintiff brought an action against Mainstay, the managed care entity. Mainstay removed the case to federal court claiming that the determinations in the case were completely preempted because they were not mixed eligibility and treatment decisions.

The Fourth Circuit agreed; in arriving at this decision the Court identified that:

> Under the teaching of *Pegram*, when an HMO diagnoses and treats a patient's condition with an appropriate medical response, even if it is at the same time making an eligibility determination, it

> does not act as a fiduciary under ERISA because the mixed eligibility and treatment decisions as a practical matter reduce to the stuff of State malpractice claims and not to traditional breach of fiduciary claims. *Id.* at 324.

The petitioner's quote from this case notwithstanding, it is clear that the Fourth Circuit approvingly cited *Pegram*. Ultimately, the Court dismissed the claims because it identified that the managed care entity made no mixed eligibility and treatment decision because it had made no medical necessity decision.

It is to be noted that although the petitioners cite the Third Circuit decision in *Pryzbowski* and the Fourth Circuit's decision in Marks as supporting alternative interpretations of *Pegram*, the Eleventh Circuit in Land identified that both Circuit courts have approvingly cited *Pegram*:

> We find additional support for our holding in decisions of the Fourth and Third Circuits, which cited *Pegram* with approval, but nevertheless concluded that the plaintiffs' claims were preempted. See *Marks v. Watters*, 322 F.3d 316, 324, 327 (4th Cir. 2003) (recognizing Pegram's teaching that "mixed eligibility and treatment decisions as a practical matter reduce to the stuff of State malpractice claims and not to traditional breach of fiduciary duty claims," but determining that the plaintiff's HMO did not make a treatment determination when the decision to release him from psychiatric care was made solely by his physician and the HMO case manager had no input in that decision); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 274 (3d Cir. 2001) (citing *Pegram* with approval and reiterating the validity of its prior holdings that

> state law claims are not preempted when "the HMO ... assumes the dual role of an administrator of benefits and a provider of medical services," but finding that the plaintiff's claims "were limited to [the HMO's] delay in approving benefits, conduct falling squarely within [the] administrative function"). *Land* at 20-21.

3. The Defendants Cite Cases That Are Not Relevant.

The petitioners also cite outdated or irrelevant cases in support of their position. First, although the petitioners cite pre-*Pegram* cases these decisions are no longer relevant and they maintain no precedential value.

Other cases the petitioners cite are irrelevant. In *Caffey v. UNUM Life Ins. Co.*, 302 F.3d 576 (6th Cir. 2002), as the petitioners acknowledge, "the court did not specifically discuss *Pegram*." Petitioner's Memorandum of Law at 14. Thus, nothing can be gleaned from case that did not address *Pegram* and its jurisprudence. And in *Howard v Coventry Health Care of Iowa, Inc.*, 293 F.3d 442 (8th Cir. 2002), the defendants made a determination regarding the use of in- and out-of-network providers, a determination that has nothing to do with the type of medical decision making identified in *Pegram*.

B. There Is Only One Case That May, In Some Manner, Partially Conflict With The *Pegram* Jurisprudence.

There is only one court which has failed to rule consistent with *Pegram* although citing *Pegram* and its jurisprudence approvingly. In *Roark v. Humana, Inc.,* 307 F.3d 298 (5th Cir. 2002), *petition for cert. filed*, 71 U.S.L.W. 3791 (U.S. June 20 2003) (No. 02-1826), and *petition for cert. filed sub nom. Aetna Health Inc. v. Davila,* – U.S.L.W. – (U.S. June 20, 2003) (No. 02-1845), the Fifth Circuit Court of Appeals ruled on a number of district court cases which had found preemption. The Court, in citing to *Pegram* identified that the "mixed eligibility and treatment" language in *Pegram*

> gives further reason to doubt that ERISA preempts medical malpractice claims such as the Roarks'. In holding that the plaintiff did not state a claim under § 502(a)(2), the Court, 530 U.S. at 236-37, expressed disbelief that ERISA preempts such claims. *Id.* at 41.

Despite its support of altering ERISA jurisprudence in the Fifth Circuit, the Court felt constrained by its prior holding in *Corcoran* and affirmed the dismissal of the Roarks' claims. The Court provided a mandate for the entire Fifth Circuit when it wrote:

> If we were writing on a clean slate, or deciding this en banc, the Roarks would have a strong case against ERISA preemption. But, as a panel we are bound by Corcoran. Id. at 41-42.

However, despite the panel's approving citation of *Pegram*, there was no *en banc* review of the case.

Thus, in reviewing all the cases, it is clear that the petitioner's position that there is great confusion is incorrect. Indeed, there is considerable uniformity of opinion among the courts that the new jurisprudence in ERISA applies to claims of mixed eligibility and treatment decision making and that these claims should be treated under state medical malpractice law. Indeed, only one court has failed to correctly decide a matter pursuant to *Pegram's* jurisprudence; however, that court correctly identified *Pegram's* applicability. The respondent argues, accordingly, that there is no confusion among the courts and this Court's intervention is unnecessary.

POINT III

CONGRESS HAS FAILED TO RESOLVE THE ISSUE IN THIS CASE AND THIS COURT SHOULD NOT LEGISLATE FOR CONGRESS

It is an established principle that courts should not legislate where Congress has failed to act. As Justice Rehnquist has commented about Congress' failure to act in *Bob Jones University v. United States,* 461 U.S. 574, 622 (1983): "Whatever the reasons for the failure, this Court should not legislate for Congress."

Congress has repeatedly attempted to resolve the issue of ERISA's impact on lawsuits against managed care entities. And Congress has repeatedly failed to resolve this issue. According to its own principles, this Court should not legislate for Congress.

CONCLUSION

For these reasons, the respondent respectfully requests that the writ of certiorari be denied.

Respectfully submitted,

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